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FEB 17 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

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1. PLACE OF DEATH

County Marion

Registration District No. 1040

Township Miller

Primary Registration District No. 6276

City (No. 1)

File No.

Registered No. 2

St. Ward 63

2. FULL NAME

(a) Residence, No. St.

Ward (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single 0

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-14-1939

7. AGE YEARS 1 MONTHS 5 DAYS 10 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Marion County (STATE OR COUNTRY) Missouri

13. NAME John A. Rollins

14. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY)

15. MAIDEN NAME Janette Leavitt

16. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY)

17. INFORMANT John Rollins (ADDRESS) Dixon, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Wheeler Cemetery DATE 1-26 1941

19. UNDERTAKER Fred H. Gilbert (ADDRESS) Dixon, Mo.

20. FILED 2-1 1941 CWWinkelman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 24, 1941

22. I HEREBY CERTIFY That I attended deceased from January 20 1941, to Jan. 23 1941. I last saw him alive on January 22 1941. Death is said to have occurred on the date stated above, at 9 A. m.

The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia
Date of onset
Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) J. R. K. W. Meigsaw M. D. (Address) Dixon Mo.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 338!

Registration District No. 1040

Primary Registration District No. 6276

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Marion
(b) City or town Miller
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution. (Specify whether

In this community
years, months or days)

3. (a) PRINT
FULL NAME Le Roy Rallins

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex M 5. Color or
race W

6. (a) Single, widowed, married,
divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if
alive _____ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 5 10 hr. min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

12. Name _____
13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____

- (c) City or town _____
(If outside city or town limits write "RURAL")

- (d) Street No. _____
(If rural, give location)

- (e) If foreign born, how long in U. S. A. ? _____ years.

CERTIFICATION

20. DATE OF DEATH. Month Jan day 24
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

- that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

- Immediate cause of death _____

- Bronchial pneumonia

- Due to _____

- Due to Bertusis Prior to 2 weeks

- Other conditions _____

- (Include pregnancy within 3 months of death)

- Major findings: _____

- Of operations _____

- Of autopsy _____

- Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____

- (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

- While at work? _____ (Specify type of place)

- (e) Means of injury _____

23. Signature D. W. Meegan (M.D. or other)

- Address Dixon Date signed 1/11/41

